

we are all called upon to treat, represents, in a conservative estimate, 50 or 60 per cent of all our patients. In treating these cases, many of us either entirely ignore the value of psychotherapy or utilize it blindly and unintelligently.

Doctor Johnson is to be congratulated on his clear exposition of psychotherapeutic aims and methods. A careful study of Doctor Johnson's paper will be of value to us all, wherever our special interest in medicine may be, and I find myself even more thoroughly in accord with Doctor Johnson's views after a study of his paper than I was when I heard him read it.

✱

CLIFFORD W. MACK, M. D. (Livermore Sanitarium, Livermore).—The treatment of mental and functional nervous diseases was for a long time in medical practice confined entirely to the somatic approach. Doctor Johnson has given us a very sane and clear-cut discussion of the treatment of these illnesses by psychotherapy. In this analysis he does not neglect the physical side, but at the same time he shows that the mental symptoms should be attacked by study of the psychic mechanism. We have long since passed the time when the mental and nervous patient is treated solely by correcting the physical abnormalities by surgery, or only on the basis of some reflex disturbance.

One of the most difficult tasks is to convince the family and friends that the essential features of the illness are in the realm of the patient's psychic or emotional life, and that they are not caused by some bodily disease. The patient even may grasp this idea much more readily than members of the family. I fully agree with Doctor Johnson as to the necessity of the reeducation of the family as well as the patient. I have often seen the work of many weeks destroyed in a short interview with the patient by some member of the family who wished to practice his or her own type of psychotherapy, or present some new theory about the illness.

There is only one point which I wish to add, and that is to call attention to the importance of suggestion as well as psycho-analysis. It may properly be argued that suggestion is only symptomatic treatment, but in no field of medicine can we neglect the value and usefulness of something that will alleviate or nullify troublesome symptoms. Doctor Johnson's exposition of the subject is of very valuable assistance to all of us engaged in treatment of nervous and mental patients.

✱

THOMAS G. INMAN, M. D. (2000 Van Ness Avenue, San Francisco).—This article by Doctor Johnson may be taken somewhat in the nature of a declaration of principles signaling, as it does, his entrance into the field of neuropsychiatry in California. And these principles prove to be quite sound, when gauged by modern conceptions of mental disorders.

As he has intimated, rule-o'-thumb methods are insufficient in themselves, and no hard-and-fast rule can be laid down which will be applicable to each individual patient. Yet, method is necessary, and every physician doing this kind of work must have a definite plan which he uses in his search for the causes of the disorder at hand.

Doctor Johnson has outlined very closely the aims of such an investigation, as well as the direction which treatment must take. His broad views inspire confidence, and lead to the hope that his work here may bring about a more complete understanding of this, as yet, obscure subject.

The closing comments upon the method of commitment of the insane in California voices the opinion of everyone interested solely in the personal welfare of these unfortunate patients. The primitive methods now in force seriously interfere with the early institution of treatment, and undoubtedly do much to prolong the period of hospitalization.

COMPULSORY HEALTH INSURANCE*†

By FREDERICK L. HOFFMAN, LL.D.
Philadelphia, Pa.

XI

SOCIALIZED medicine is reviewed in the *Literary Digest* of December 29, 1934, in its annual review of progress made during the year in science and engineering. After an enumeration of outstanding discussions in the field of medicine, it is said:

"Socialized medicine," or the placing of physicians on government payrolls, and "health insurance," or provisions of medical treatment for the payment of small, regular, voluntary fees, were leading plans proposed. Both were bitterly opposed by officials of the American Medical Association, but health insurance was advocated by increasing numbers of physicians, dentists, nurses, and social agencies; by city, county, and state medical societies, and by the American Hospital Association, and the American College of Surgeons.

In this statement, however, the compulsory feature of the system is not emphasized, and that goes to the root of a very disturbing situation. It is seriously to be questioned whether the medical profession at large is more than vaguely conscious of what is actually implied in the various proposals. And unless it is aroused out of its apathy it may realize when it is too late that its professional independence has been sacrificed for a mediocre amount of economic security.

MAJOR PROPONENTS OF COMPULSORY HEALTH INSURANCE

The propaganda for compulsory health insurance is largely in the hands of and within the control of nonmedical men supported, in part if not wholly, by some of the great foundations more or less international in character and purpose. The outpourings of briefs and reports reveal no thorough grasp of the proper medical considerations, but rather the academic viewpoint of the green table and easy chair philosophy. It is supported by pleas for the poor or underpaid workers whose medical needs are said to be badly neglected. It insists that the medical care of the lower-wage group should be raised to the very best that can be provided, although the richest nation of the earth could not meet the expenses which would call into being a huge administrative apparatus largely of a nonmedical nature. The British health insurance committee makes the bold assertion that this is an "Act to provide against loss of health," but no agency has come into existence in the twenty-one years of its life to provide in an effective manner against the onset of disease. It may be safely asserted that the health of the British

* One of a series of articles on compulsory sickness insurance written for CALIFORNIA AND WESTERN MEDICINE by the well-known consulting statistician, Frederick L. Hoffman, LL.D. Articles in this series were printed in issues as follows: I, in April, 1934, page 245; II, in May, page 361; III, in June, page 411; IV, in July, page 33; V, in August, page 114; VI, in September, page 177; VII, in October, page 262; VIII, in November, page 323; IX, in December, page 398; X, in February, 1935, page 108.

† Note—As stated in the editorial masthead, "Authors are responsible for all statements, conclusions and methods of presenting their subjects" in CALIFORNIA AND WESTERN MEDICINE. See also editorial comment in this issue, page 190.

worker, or of the insured members of his family, is not much better today than it was before the Insurance Act came into being.

HEALTH INSURANCE VERSUS SICKNESS INSURANCE

For the insurance of health is a totally different matter from insurance against loss of health through sickness, demanding chiefly medical treatment or more or less successful curative measures. The Act provides compensation for loss of employment due to ill health, but does not go to the root of a radical change in housing and living habits, which are possible factors responsible for widespread physical impairments. Through other agencies, it is true, every government the world over aims at an improvement of environment, as well as of the living habits, of its wage-earners to promote health and long life; but these agencies are not intelligently correlated to proper health insurance, being rather in the nature of relief agencies concerned with the economic consequences of sickness.

ROOT OF MOST ILLNESS

A careful review of the annual reports of health officers of England and Wales, Scotland and Northern Ireland is not suggestive of the fact that national health insurance forms an integral part of the public health organization. The root of most of the illness lies in the effect of housing and nutritional, as well as industrial, conditions inimical to good health and long life. In other words, the prevention of disease is still in a very backward condition, while vast amounts of money are being spent on the cure of disease, mostly in the nature of minor ailments. This is clearly shown in the last report of the chief medical officer of the British Ministry of Health (1933), who gives a table showing the proportion of cases of certain diseases to the total cases treated by insurance practitioners in 1933, which is supposed to be a representative sample of the entire experience. The table shows that out of 125,646 cases treated, 29,698, or 23 per cent, were for bronchitis, tonsillitis, nasal catarrh, colds, etc. The next most important item was influenza, represented by 14,905 cases, or 11.9 per cent. The third factor of outstanding importance were diseases of the digestive system, with 13,915 cases, or 11.1 per cent. These three groups, therefore, represented 46.6 per cent of the total.

Of the remainder, lumbago and rheumatism came first, with 11,329 cases, or 9 per cent of the whole; followed by injuries and accidents with 10,809 cases, or 8.6 per cent, and abscess, boils, and other septic conditions with 8,803 cases, or 7 per cent. Thus, these six groups combined, mostly of a minor nature and involving heavy expenditure on the part of the insured, represented 71.2 per cent of the total cases treated.

With regard to chronic diseases, tuberculosis, all forms, was represented by 905 cases, or 7 per cent of the total; organic heart disease, with 1,589 cases, or 1.3 per cent; anemia with 1,578 cases, or 1.3 per cent; diseases of the nervous system,

with 7,046 cases, or 5.6 per cent; and skin diseases, with 6,112 cases, or 4.9 per cent.

Of the more serious and often prolonged respiratory diseases, pneumonia accounted for 1,699 cases, or 1.4 per cent of the total. Diseases of the genito-urinary system numbered 3,854 cases, or 3.1 per cent; while malignant disease or cancer numbered 221, or 0.2 per cent.

LIMITATIONS OF NATIONAL HEALTH INSURANCE

Hence it is clear that most of the money in national health insurance is spent upon trivial ailments, many of which are merely alleged conditions to secure relief by unemployment. Hospital care and surgical treatment are not provided for by national health insurance, but if provided would easily double the cost of the system.

Comparing the death rates for some of the more serious afflictions, including chronic diseases, the record for the last ten years is as follows: Erysipelas increased from 1.8 per 100,000 to 2.5; encephalitis lethargica from 0.9 to 2.1; cerebrospinal fever from 0.9 to 3.0; cancer from 122.9 to 151; nonmalignant tumors from 2.7 to 3.9; chronic rheumatism and osteo-arthritis from 5.9 to 7.9; diabetes from 11.9 to 15.2; diseases of the thyroid and parathyroid glands from 2.7 to 4.5; cerebral thrombosis from 6.2 to 11.6; paralysis agitans from 1.9 to 3.5; disseminated sclerosis from 1.9 to 2.2; aortic valve disease from 7.8 to 8.4; mitral valve disease from 24.6 to 25.2; myocardial degeneration from 40.4 to 117.4; diseases of the coronary arteries and angina pectoris from 3.8 to 19.1; disordered action of heart from 1.6 to 6.5; aneurysm from 2.7 to 3.2; lobar pneumonia from 24.1 to 24.9; ulcer of the stomach or duodenum from 6.8 to 9.9; appendicitis from 7.2 to 7.5; hernia and intestinal obstruction from 11.1 to 12; biliary calculi from 2.6 to 3; diseases of the gall-bladder and ducts from 1.7 to 2.8; diseases of the pancreas from 0.6 to 1.3; nephritis, all forms, from 33.2 to 40.6; other diseases of the kidney and annexa from 1.6 to 2.6; calculi of the urinary passages from 0.8 to 1.1; diseases of the prostate from 11.6 to 22.4; diseases of the skin and cellular tissue from 4.5 to 4.9; diseases of the bones from 2 to 2.4.

On the other hand, of course, many diseases have diminished in incidence, but I have for the present considered only those which I am claiming are not receiving adequate and proper attention under national health insurance. The foregoing figures have all been abstracted from the annual report of the Registrar General for 1932, covering the period of 1922-1932.

SOME BRITISH OPINIONS ON THE LIMITATIONS OF HEALTH INSURANCE

The present limitations of national insurance in Great Britain are recognized by every authority on the subject, and countless reports voice the opinion of its inadequacy in unmistakable terms. For example, at a recent meeting of the Nottingham Insurance Committee, the chairman, in his report, observes:

"The work in insurance committees is to deal with the maintenance of a healthy life of insured persons, and to provide medical attendance and other measures for such of them as fall out of health, and the extension of the medical service should, I think, be one of the first considerations. There is no need for me to dwell on the present inadequacy of the medical service, well though the majority of panel practitioners play their part. . . . I am of the opinion that it is essential in the interests of insured persons that the supplementary services, so much discussed in the past, are necessary today in order to secure a complete and adequate medical service for the insured community, and in addition thereto a system of medical treatment and attendance by panel practitioners to the dependents of insured persons, administered by and through insurance committees."

Furthermore, the chairman observes:

"I do feel, however, that eventually the National Insurance Act will of necessity have to be amended on the lines of the new Unemployment Insurance Act so as to bring boys and girls on leaving school within its scope, as the inconsistency in our two great social schemes cannot, I think, be reconciled for long." (*National Insurance Gazette*, November 15, 1934.)

In a report concerning the Medical Service Subcommittee of the London Insurance Committee, October 25, 1934, mention is made of the procedure followed in the case of a panel doctor who had failed to diagnose correctly cancer of the lung. The subcommittee said that, as a result of their consideration of the case, they found that the insured person had received proper attention, although he died from a cause not diagnosed. The subcommittee recommended concurrence with local medical committees' view that the following services were outside the scope of terms of service, and practitioners concerned might charge patients privately therefor: "(1) Enucleation operation for removal of tonsils by dissection; (2) ultra-violet rays for asthenia; (3) local treatment with Tungsten arc lamp for ringworm on neck; (4) estimation of refraction—subjective and by retinoscopy for presbyopia; (5) retinoscopy and prescribed spectacles; (6) retinoscopy and ophthalmoscopy; (7) ultra-violet rays for postherpetic neuralgia; (8) retinoscopy and prescribing glasses; (9) dilation and curettage for chronic endometritis; enlarged uterus, chronic backache, discharge and menorrhagia."

I quote also from a report of Dr. L. Llewellyn-Jones, one of the foremost authorities on national health insurance in England, who presided at the meeting of the Flintshire committees, November 8, 1934, and is stated to have said that

"He himself was sorry to see the tendency nowadays in the direction of bureaucratic policy, which he thought was a huge mistake in the administration of national health. The experience gained in the last twenty-one years of the benefits of national health insurance had shown that there was a great deal to be done before they could sit down and say they were well satisfied. The scope of medical benefit at present was a comparatively narrow one. As soon as an insured person required treatment which necessitated a consultant or the services of an expert surgeon the resources of insurance committees came to an end, and they were not in a position to arrange for that further treatment. There was nobody today who did not feel there was a gap which ought soon to be filled if they thought that the scheme was what they thought it was going to be twenty-two years ago. There was another line of advance which he would like to see. And that

was a closer connection and correlation between the insurance services and the public health services of the local authorities. There was a section of the 1911 Act which seemed to contemplate that, but it had never been put into operation. In 1924, when the Government brought in a Consolidating Act, that section was dropped. There ought to be much closer coöperation between the two bodies than existed at present. He would like to see an attempt made to bridge over the gap between the time a child left school and the time it entered the national health services. They, as insurance committees, could do a great deal in the way of impressing public opinion with the reasonableness of what they were claiming, and as regards paying more attention to matters of public health whether on the clinical or on the preventive side."

The foregoing extracts will clearly illustrate the limitations of health insurance inherent in the system, and the inadequacy of the contributions to provide for all the emergencies that may arise chiefly, however, in connection with prolonged cases of chronic illness which are not properly provided for under the present system.

AN ILLUMINATING SIDELIGHT ON PANEL PRACTICE

An illuminating sidelight on panel practice is contained in an article in the London *Lancet* of September 29, 1934, which bears the suggestive heading "Placebo Prescribing." Placebo, according to the medical dictionary, is "An indifferent substance, in the form of a medicine, given for the moral or suggestive effect." In other words, placebo is a pretense and a fraud. In the article referred to, the question is raised as to whether patients as a rule expect a prescription or a bottle of medicine when they consult a doctor, it being stated that the chemists' accounts for insured persons increased from a total of about \$9,046,000 in 1932 to a total of about \$9,632,000 in 1933. It is then said:

"All doctors are familiar with the patient's statement that the very first dose did him good, and it would be a foolish man who refused to repeat that mixture. There is the story of the old lady who could not do without her cough mixture, and on one occasion when she sent up for it and her doctor was out his wife put an ounce of Camp coffee in the bottle, filled it up with water, and told the messenger that the mixture has been changed. Most practitioners who dispense keep a mixture labelled "ADT": A for any, T for thing, D for what you like—to be used for people who are thought not to require medicine at all, but who would consider themselves neglected if they did not get something."

UNNECESSARY MEDICINE AND ITS COST

Attention is next drawn to the fact that Sir George Newman, in his annual report, raised the question of unnecessary medicine and its cost. In other words, a vast amount of prescribing serves no useful purpose, but is in the nature of a fraud upon the insured who are given a medical concoction as a matter of pretense and downright imposition. But the vast amount of trivial ailments in the doctor's practice could not result in any other procedure. As I said before, the patient is chiefly interested in a certificate for incapacity for work entitling him to a cash benefit, and as long as this is true the condition referred to is not

likely to be improved upon. The article observes that the general cost of prescribing has gone up and continues to go up. Sir George Newman states that is due to the modern tendency to prescribe expensive drugs, such as insulin and liver extract, and that inasmuch as these drugs are necessary, it becomes more than ever important that money which should be available for their cost is not frittered away in placebos. But the doctor in question has no alternative that may involve the risk of losing his clients who would transfer to a more complacent medical attendant. As said in the *Lancet* article:

"The determining factor in the doctor's view is the fear of offending his patient, thereby risking the loss not only of that patient, but possibly his family and relatives. But whilst cantankerous patients leave Dr. A., they also leave Dr. B. and Dr. C., so that what Dr. A. loses in one family he gains in another."

In a further article in the *Lancet* on the same subject, it is said, referring to Sir George Newman's report:

"You say 'the public appreciates what it has to pay for.' As it is, panel patients have a suspicion that the panel doctor's medicines are not so good or 'so strong' as those prescribed by private doctors or by the same doctors for their private patients. A common remark is: 'I told him I didn't want any panel stuff and he gave me a bottle of really good medicine. You see they won't let them give really good medicine on the panel except when you are very ill indeed.' Whether we are wise to attempt to take away the prop that a bottle of medicine provides when we have so little else curative in our armamentarium is again another matter. It seems likely that the quack dispenser would have scope for a flourishing trade if doctors really gave medicine only when it is required. Before we manage to do without a bottle of medicine we shall probably have to invent some other symbol or idol."

NUMBER OF PERSONS INSURED IN GREAT BRITAIN

Several references have been made in this and previous papers to the increasing sphere of national health insurance in Great Britain by the inclusion of new categories of members, particularly the young between sixteen and eighteen years of age. According to a recent statement by Sir Hilton Young of the Ministry of Health, the numbers of persons in Great Britain who, on December 31, 1933, were insured for health and pension purposes, respectively, were approximately 18,481,000 and 18,793,000. The number of insured persons under twenty years of age on December 31, 1931, was approximately 2,500,000. Thus, to the extent that the number of insured increases, the sphere of the private practitioner is curtailed. In Germany the number of members in compulsory health insurance sick funds increased from 17,539,000 in January, 1933, to 20,163,000 in June, 1934. The experience elsewhere has been similar.

The application of the foregoing facts and information, concerning the experience of compulsory health insurance abroad, to American conditions is obvious. Unless we are ready to merge a large proportion of our doctors in a federal health insurance service, we had better consider the possible effects on the general medical practice. Of course, the agitation for compulsory health in-

surance rests, to a large extent, upon the free treatment of the poor for which compensation should be made by the State.

HOW CAN INDUSTRY ASSUME THE BURDEN OF NATIONAL HEALTH INSURANCE

The demand that industry shoulder a large proportion of the cost of compulsory health insurance is a preposterous imposition. Industry as it is has a hard enough time to avoid bankruptcy in view of the immense hardships of interstate competition. Its position would be infinitely worse with compulsory health insurance demanding that 50 per cent of the contributions be paid for by the employer. Nothing would suit European nations better than for us to assume such a colossal burden, to equalize still further the economic differences between this and other countries. Efficient medical practice is difficult enough as it is, and should not be burdened with an immense variety of rules and regulations and supervision and control on the part of state and federal authorities which would hinder its progress and curtail opportunities now open to all physicians engaged in private practice. Once such a bondage has become an established fact, it is extremely difficult for any country to do away with it.

PROPOSED BILL OF THE AMERICAN ASSOCIATION FOR SOCIAL SECURITY (EPSTEIN BILL)

Regardless of our precarious financial situation, social reformers are pressing their plans for socialized insurance with increasing vigor. An organization known as the American Association for Social Security, according to the *New York Times*, has made public its Social Security Bill[†] which, it is stated, will be introduced as a model measure in forty-three state legislatures now convening, and the provisions will be made the basis of a federal subsidy bill to be introduced into Congress in the near future. It is said, in the article referred to, that "the two steps combined are designed to provide a health insurance system under which the great proportion of those earning less than \$3,000 a year would receive essential medical services and part compensation for loss of income by illness."

The object of the federal bill is "the establishment of a system of health insurance which will provide protection of the population which is unable to budget individually for adequate health services or to bear the loss of income by illness. . . . Its basic aim is to equitably distribute the burden that illness involves. There is no attempt in this bill to reorganize the medical profession as such in any manner whatsoever." All this is mere meaningless verbiage, for the moment such a bill is enacted the medical profession will be drawn into it on a large scale, and will be divided into those who are on the Panel and those who are not. Compulsion for the payment of the contributions will be a most essential feature, and a heavy burden both upon the employers and the employees. In view of the reckless spending of

[†] For other comment concerning this bill, see *Journal of the American Medical Association*, February 2, 1935, p. 400.

federal money, the enactment of radical legislation of all sorts is by no means improbable, and such a measure may become a law unless the medical profession uses its utmost influence to protect its interests against adverse legislation.

BRITAIN'S FIGURES ON THE COSTS OF ITS HEALTH INSURANCE

What, in the long run, such a system may amount to in dollars and cents is best illustrated by the British experience with a record of nearly a quarter-century available. Since 1921 the total receipts from all sources, contributions, parliamentary grants and interest, have amounted to \$3,187,781,000. Of this, the amount paid by direct parliamentary grants is represented by the tidy sum of \$665,602,000. Of the total expenditure, \$420,122,000 represents the cost of administration, compared with \$140,641,000 for maternity benefits and \$755,000,000 for medical benefits. This represents the cost for England and Wales only, with an approximate population of about forty million.

At the present time the annual receipts from contributions, parliamentary grants, interest, etc., amount to about £32,000,000, or not quite \$150,000,000. That applied to the American population, with due regard to the higher standards of living and higher cost of compensation, would bring the annual cost of a system of socialized insurance to possibly a billion dollars, considering that many more benefits would be expected in this country than abroad.

COMPARISON OF GENERAL REVENUES OF CALIFORNIA AND MASSACHUSETTS

Since the States would have to bear a large proportion of the expense, let us consider the facts for the State of California compared with the State of Massachusetts, derived from the latest figures available from the Census Office.[†] For 1932 the per capita revenue of California was \$106.85, while for Massachusetts, 1931, the corresponding figure was \$89.51. The per capita expenditures were \$113.78 for California and \$96.31 for Massachusetts. The per capita gross debt, less sinking-fund assets, was \$186.15 for California and \$101.77 for Massachusetts. The per capita gross debt, less sinking-fund assets, has increased in California from \$55.01 in 1912 to \$142.81 in 1922 and \$186.15 in 1932, and in Massachusetts from \$75.28 in 1912 to \$82.30 in 1922 and \$101.77 in 1931.

RECENT HEALTH AND SANITATION EXPENDITURES IN CALIFORNIA AND MASSACHUSETTS

In an estimated population of about six million for California, the amount spent on health and sanitation in 1932 was \$15,369,000. In Massachusetts, with an estimated population of about 4,500,000, the amount spent on health and sanitation in 1931 was \$22,096,000. What is to be the future of State finances under such alarming conditions? In its last analysis, the burden of tax-

ation falls most heavily upon the productive industries and the wage-earner's income. With the higher cost of living, which is inevitably in prospect, and with a substantial reduction in wages on account of health insurance or social insurance payments, the wage-earner may well pause to give approval to this fantastic scheme of reform which has little to commend it.

MUTUAL HEALTH SERVICE OF WAYNE COUNTY, MICHIGAN

There is a way out of the difficulty which demands attention. In Detroit, Wayne County, Michigan, the county medical society has inaugurated a voluntary plan of medical service, with every assurance of success. What is possible in Detroit is possible in every other community in the United States, and the facts of the situation should be carefully studied by every local medical society.

In brief, the Wayne County Medical Society provides for a coordinating center, with a social service set-up, for those cases which require assistance in obtaining and paying for complete medical service, including hospitalization and medical, dental, nursing, and pharmaceutical service. This is more than the European plans provide at the present time, or are ever likely to provide. All the members of the society become the active staff caring for patients, and all forms of medical care, including consultation, x-ray, and laboratory procedures, are to be performed in the office or laboratory of the physician or at the hospital where he takes the patient. The plan includes hospitalization, all the major hospitals of Detroit, except one, cooperating.

Industrial concerns are cooperating by making the service known to their employees, while factories and shops also are cooperating by giving information and in the collection of accounts. The plan has been welcomed by every employer approached.

If the patient has no personal physician, he may choose one, and an identification card is given him to be presented to the doctor of his choice. If several physicians and a hospital cooperate in the care of a case, the bills or fees are combined into one bill, the physicians and hospital, not the Bureau, setting the fee. The payments when received are then distributed to each cooperating physician, hospital, dentist, or nurse. By this method the recognized patient-physician relationship is preserved. It is explained that this plan does not affect compensation cases. The patient has free choice of hospitals, specialists, and laboratories exactly as in private practice.

It is furthermore said, "The most important feature of this plan is that it places complete medical and hospital services within the reach of every worthy patient, and provides an easy payment for the settlement of medical bills."

The following facts are of particular importance. Wayne County has about 7,000 medical units, doctors, dentists, nurses, hospitals, and pharmacists, and approximately 1,100 industrial concerns employing more than one hundred workmen each. The cooperation of all these is neces-

[†] Including the State and all local administrative areas.

sary if the plan is to be successful. The Detroit plan is as yet in its initial stage, and "the work of contacting employers has been sandwiched in between many other duties so that, to date, only thirteen industrial concerns have been approached. The total employment at the plants contacted is approximately 65,000 men. In each case the industrialist stated he would gladly tell his workers; he would also verify employment, wages, etc., in the investigation of the patient. In every case the manufacturer is willing to assist us in making collections. This is not surprising, because the plan offers many distinct advantages to the employer, such as (1) certainty that the employee will be well cared for; (2) relief from a portion of the necessity for employee loans; (3) greater efficiency through better health of employees; (4) one centralized bureau with which to cooperate; and (5) no dues, fees or payments of any kind before actual service has been received."

HOW THE WAYNE COUNTY PLAN HAS WORKED OUT IN PRACTICE

The Bureau began to function in February, 1934, and up to August 18, 1934, had handled 1,085 individual cases. According to *The Medical News* of Detroit for October, 1934, "the number of employees involved in the industries already actively cooperating with the plan is 229,980." In brief, the Detroit plan provides complete medical and hospital service within the reach of every worthy patient by means of an easy-payment plan for the settlement of medical service bills. Physicians and hospitals, not the Bureau, set the fee. Thus, the self-respect of the patient is preserved regardless of what the situation may be. Nothing more admirable has been evolved in all the numerous plans for socialized medicine on a compulsory or voluntary basis. As observed in a report on the bill in *The Journal of the American Medical Association* for September 8, 1934: "The plan should increase the health and happiness of Detroit and Wayne County citizens, as it provides a method whereby people can procure needed medical services. It should remove a large proportion of the financial reasons for delaying medical service. The consolidation of medical and hospital bills, with the arrangement of definite terms at the time the service is rendered, should result, with the cooperation of the employer and all concerned, in an increased ratio of collections."

And finally: "Physicians send their bills computed at their usual fees for these patients to Bureau headquarters, giving certain details of their charges. The physician does not make collection of these charges—the central bureau makes arrangements for collections and has the cooperation of the employer. To defray the cost of operating the Bureau, 10 per cent of sums actually collected is retained by the Bureau."

As regards those unable to pay for medical services at the time such service is rendered, it is said that in such cases the patients are always returned to their family physician with a plan of deferred payments, and that "the majority of these patients sought charity because they did not have

sufficient cash in reserve to meet the full fees incident to a medical emergency. Their prime need was credit, not free medical care."

ADVANTAGES OF THE WAYNE COUNTY PLAN

Here, then, is a plan worthy of the most careful consideration on the part of those who sincerely believe that some form of medical reorganization is necessary to provide for the needs of poorly paid workers unable to meet their medical bills. The Detroit system eliminates entirely the need of compulsion and state interference, and avoids the extremely costly advisory bodies which come into existence in a system of compulsory health insurance. It preserves the independence and integrity of the medical profession and avoids class distinction both on the part of the beneficiaries of the system and the doctors. It eliminates an enormous amount of political discussion incident to compulsory administration, and leaves the doctor time for the scientific study of medicine. It should go far to improve the general health situation and to lower the death rate from preventive or curable diseases.

DEATH RATE IN BRITAIN AND THE UNITED STATES

With reference to the death rate, it may be pointed out that the rate for England and Wales in 1933 was 12.3 per one thousand, compared or contrasted with a rate of 10.7 for the United States during the same year. In 1912, when the British system was established, the death rate for England and Wales was 13.4 per one thousand, while that for the United States registration area for the same year was 13.9. In tabular form the comparative results are as follows:

| COMPARATIVE DEATH RATES PER ONE THOUSAND, 1912 AND 1933 | | |
|---|-------------------|-------------------------|
| | England and Wales | U. S. Registration Area |
| 1912 | 13.4 | 13.9 |
| 1933 | 12.3 | 10.7 |

Hence it is shown that while there was a decrease of 1.1 per one thousand in the death rate for England and Wales, the corresponding decrease in this country was 3.2. The first was achieved with health insurance and the second without it. The boasted benefits to the British population are largely a matter of conjecture, for in its last analysis the death rate is the court of last appeal in a discussion of this kind. The questions involved may be presented to advantage in a somewhat more convincing method of details.

Considering twenty-eight leading causes of death in the United States and England and Wales for the year 1933, it appears that eighteen causes show a lower death rate in this country, while ten show a higher rate. The combined mortality from those diseases showing a lower rate in this country was 747.5 for 100,000 for England and Wales, and 507.4 for this country; while for the ten causes with a higher rate in this country the combined rate was 211.9 per 100,000 for England and Wales, and 298.6 in this country. The diseases showing a lower rate for this country are given in Table 1, with the rates per 100,000 population.

TABLE 1.—*Diseases Less Common in the United States*
(Rate per 100,000)

| | U. S. Regis- tration Area | England and Wales |
|---|---------------------------------|-------------------------|
| Influenza | 26.4 | 56.7 |
| Erysipelas | 1.6 | 3.0 |
| Tuberculosis (all forms)..... | 59.5 | 82.4 |
| Cancer and other malignant tumors.. | 102.2 | 152.6 |
| Acute rheumatic fever..... | 2.0 | 3.2 |
| Chronic rheumatism, osteo-arthritis | 1.3 | 8.0 |
| Diseases of the thyroid and para- thyroid glands | 3.3 | 4.6 |
| Anemia | 3.4 | 6.7 |
| Diseases of the heart and circula- tory system | 249.8 | 330.4 |
| Chronic bronchitis..... | 1.5 | 18.4 |
| Bronchopneumonia | 29.3 | 40.8 |
| Asthma | 1.5 | 4.4 |
| Pleurisy | 2.1 | 2.3 |
| Diseases of the buccal cavity, etc..... | 4.5 | 4.9 |
| Ulcer of the stomach and duodenum | 6.0 | 10.2 |
| Hernia, intestinal obstruction | 10.0 | 11.8 |
| Diseases of the skin and cellular tissue | 1.7 | 4.9 |
| Diseases of the bones and organs of locomotion | 1.3 | 2.2 |

The diseases showing a higher rate in this country are given in Table 2.

TABLE 2.—*Diseases More Common in the United States*
(Rate per 100,000)

| | U. S. Regis- tration Area | England and Wales |
|---------------------------------------|---------------------------------|-------------------------|
| Typhoid fever | 3.5 | 0.5 |
| Syphilis | 8.8 | 3.3 |
| Diabetes | 21.3 | 15.6 |
| Leukemia and pseudoleukemia..... | 3.6 | 3.2 |
| Alcoholism | 2.6 | 0.2 |
| Diseases of the nervous system..... | 104.2 | 96.8 |
| Lobar pneumonia | 36.4 | 24.4 |
| Appendicitis | 14.1 | 7.6 |
| Cirrhosis of the liver..... | 7.4 | 3.1 |
| Diseases of the genito-urinary system | 96.7 | 57.2 |

The contrast in local disease frequency is highly instructive. Obviously the diseases which should benefit most under a health insurance system are higher than they are in this country, with the important exception of syphilis, diabetes, lobar pneumonia, appendicitis, cirrhosis of the liver, and diseases of the genito-urinary system. Syphilis and genito-urinary diseases, chiefly chronic nephritis, are affected by race, being much more common among the negro population. If it were not for the negro element, our general and specific death rates would be decidedly more favorable in contrast with the returns for England and Wales. Highly significant are the high rates for rheumatic fever and chronic rheumatism in that these two diseases receive major attention under health insurance. Hence the conclusion that our health system without health insurance is decidedly more favorable than that of England and Wales, and that indications for a further decrease in specific death rates are more pronounced in this country than in England.

In conclusion, I quote an interesting paragraph from a treatise on German medicine by the Hoeber Press, recently published. It is one of a series of volumes on the history of medicine and written by one who evidently speaks with authority on the questions under consideration. Regarding health insurance, he remarks: "The financial status of the medical profession became much weakened in

1883 by the introduction of the compulsory public sickness insurance (Krankenkasse). The physician's salary for the immense amount of work required under this system is most inadequate; the insurance covers a large part of the population: workingmen, clerks and their families, and so on. At first the insured persons did not have the privilege of choosing their physicians, but as a result of the efforts exerted by the 'Verbände der Aerzte Deutschlands,' this has been changed, and now the patients do have the privilege of selecting their physicians." (*Journal of the American Medical Association*, October 27, 1934, page 1330.)

IN CONCLUSION

With this statement I leave the subject which I have tried to present impartially in the light of such evidence available to me, both from German and British sources. To my mind, there can be no other conclusion than that the adoption of compulsory health insurance is not to the interest of the American medical profession, while it is equally opposed to the best interests of the public. I have given much of my time during the last thirty years to a patient study of the facts, and my earlier convictions as regards the inexpediency of compulsory health insurance remain unchanged. I trust that what I have written will be of benefit to the American medical profession and arouse organized opposition to any and every effort to force such an uncalled for system upon the American public, who, in its last analysis, have to bear the burdens of increased taxation and decreased economic efficiency in international trade competition.

THE LURE OF MEDICAL HISTORY*

THE INFLUENCE OF CLAUDE BERNARD ON MEDICINE IN THE UNITED STATES AND ENGLAND†

By J. M. D. OLMSTEAD, Ph.D.
Berkeley

II‡

BERNARD'S INFLUENCE ON THE TEACHING OF PHYSIOLOGY IN AMERICAN MEDICAL SCHOOLS

Many of the young American physicians who listened to Bernard's lectures afterwards became professors in medical schools in the United States, but hardly one carried on research along physiological lines. Dr. Henry H. Donaldson of the Wistar Institute of Anatomy gives us a picture of conditions in the 1880's which is particularly interesting because he had his physiology under Dalton: "In the eighties the teaching of medicine,

* A Twenty-Five Years ago column, made up of excerpts from the official journal of the California Medical Association of twenty-five years ago, is printed in each issue of CALIFORNIA AND WESTERN MEDICINE. The column is one of the regular features of the Miscellany Department of CALIFORNIA AND WESTERN MEDICINE and its page number will be found on the front cover index.

† From the Division of Physiology, University of California Medical School, Berkeley.

‡ Part I of this article was printed in February issue, CALIFORNIA AND WESTERN MEDICINE, page 111.